PREMIER COMMUNITY HEALTHCARE GROUP, INC.
Discount Fee Application & Agreement

Premier Community Healthcare Group Inc provides essential services regardless of the patient's ability to pay. Discounts are offered depending upon household/family income and size. A "**Family**" is one or more persons living in one dwelling place who are related by blood, marriage or law. A "**Dependent**" is someone who lives in your household and qualifies as a dependent for federal tax purposes. Please list information below to determine if you or your family members are eligible for our discounted fees program. Once your Discount Fee Plan is determined, payment is due at time of service.

I. Household/Family Information

Member's Name(s):	Age	Relationship	Income
_____	_____	**Self** _____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

II. Income Information

Please provide proof of total household income for the last 30 days (i.e. Check Stubs, Bank/Financial Statements, SSI/Disability Letters, etc.)

III. Eligibility

With the information you presented today, it has been determined that:

☐ **You qualify** for the Discount Fee Plan checked below. **This plan is in effect for one year from today's date.** If your income changes during this time or if you obtain health insurance coverage, please notify us immediately.

- ☐ Discount Fee Plan A
- ☐ Discount Fee Plan B
- ☐ Discount Fee Plan C
- ☐ Discount Fee Plan D

☐ **You do not qualify** for our Discount Fee Plan. You will be responsible for paying full fees for your visit, depending on level of service provided these fees will be at a minimum $83-$300 for medical services and $73 for dental services. If your income changes or, if you obtain health insurance coverage, please notify us immediately.

****Any procedures that are performed during your visit (Labs, X-Rays, tooth extractions, procedures, etc) will result in an additional charge due at the time of service. The fees for these additional services will be discussed with you before services are performed.**

I certify that the above facts are true and correct to the best of my knowledge and that I understand the financial responsibilities associated with the Discount Fee Plan. I am also aware that this information may be randomly audited at any time for verification purposes. Knowingly providing false information may result in termination of services.

_____ _____

Signature of Applicant Date

OFFICE USE ONLY

No. Supported: _____
Gross Income $: _____
Income Period: _____

Income Type(s): ☐Employment ☐Self Employed ☐Disability, SSI, Pension, Retirement ☐Child Support, Alimony ☐Worker's Compensation ☐Statement of Support ☐Cash Income Verification ☐Unemployment

Care Team Member Signature _____ **Date** _____